PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155095	B. WIN	G		03/13/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOI I EIEK				OBSON RD		
HERITAG	SE PARK			FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010000							
	A I ifa Cafata Ca	da Dagardi Gardi an and	170	10000			
	_	ode Recertification and	KU.	10000			
		Survey was conducted by					
		Department of Health in					
	accordance with	42 CFR 483.70(a).					
	-						
	Survey Date: 03	/13/13					
		00000					
	Facility Number						
	Provider Number						
	AIM Number: 1	00274830					
	Surveyor: Amy	Kelley, Life Safety Code					
	Specialist						
	At this Life Safe	ty Code survey, Heritage					
	Park was found i	not in compliance with					
	Requirements for	r Participation in					
	Medicare/Medic	aid, 42 CFR Subpart					
		Safety from Fire and the					
	2000 edition of t	•					
		eiation (NFPA) 101, Life					
		C), Chapter 19, Existing					
	-	upancies and 410 IAC					
	16.2.	upaneres and 410 IAC					
	10.4.						
	This one story fo	cility was determined to					
	_	•					
	'	1) construction and was					
		. The facility has a fire					
	=	th smoke detection in the					
	ŕ	open to the corridors and					
	hard wired smok	e detectors in the resident					
	rooms on the 200	hall. The remaining					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155095	A. BUII B. WIN	LDING	01 	COMPL: 03/13/	ETED
NAME OF P	ROVIDER OR SUPPLIER		<i>5.</i> (12.)	2001 H	ADDRESS, CITY, STATE, ZIP CODE DBSON RD VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
TAG	resident rooms has smoke detectors. capacity of 180 at the time of this standard areas where the customary access areas providing for sprinklered, excess and an additional maintenance officand an additional maintenance store Quality Review by Safety Code Specion 03/18/13.	ave battery operated The facility has a and had a census of 160 at urvey. he residents have s were sprinklered. All facility services were ept one shed used for the ce and general storage I shed used for age. by Robert Booher, Life cialist-Medical Surveyor found not in compliance ntioned regulatory		TAG	DEFICIENCY		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet Page 2 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

PROVIDER'S PLAN OF CORRECTION	STATEMEN	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	JER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVE			SURVEY	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805 (X5) PREFIX (EACH OERSCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (X5) COMPLETED DATE (X5) COMPLETED DATE (X5) COMPLETED DATE (X6) COMPLETED DATE (X5) COMPLETED DATE (X5) COMPLETED DATE (X5) COMPLETED DATE (X6) COMPLETED DATE (X7) COMPLETED DATE (X8) COMPLETED DATE (X9)	AND PLAN (N OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	01	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY) DATE OATE	ı		155095				03/13/	2013
HERITAGE PARK 2001 HOBSON RD FORT WAYNE, IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 NFPA 101 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical 2001 HOBSON RD PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) DATE TO STANDARD DOORS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) DATE OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION APPROPRIATE DEFICIENCY) TAG OF THE PROVIDER'S PLAN OF CORRECTION APPROPRIATE DEFICIENCY TAG OF THE PROVIDER'S PLAN OF CORRECTION APPROPRIATE DEFICIENCY TAG OF THE PROVIDER'S PLAN OF CORRECTION APPROPRIATE DEFICIENCY TAG OF THE			L	B. WIIN	_	ADDRESS CITY STATE ZIP CODE		
HERITAGE PARK (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical FORT WAYNE, IN 46805 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCE	NAME OF P	PROVIDER OR SUPPLIEF	R					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED T	HERITAC	7CE DABK						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K010018 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical		TOL I AITT			1 OIXI V	VATNE, IIV 40005		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) KO10018 NFPA 101 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical	` ′							(X5)
K010018 NFPA 101 SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical		, and the second				CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
SS=E LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical			R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K010018	NFPA 101 LIFE SAFETY CO Doors protecting than required enc openings, exits, of substantial doors of 1¾ inch solid-t capable of resisti minutes. Doors i only required to r smoke. There is closing of the door with a means suit closed. Dutch do permitted. 19.3 Roller latches are regulations in all Based on observ facility failed to to 1 of 1 Heritag of 1 employee be and latch into the deficient practice residents in the I which has enoug residents and sta room. Findings include a. Based on obse Maintenance Su 1:20 p.m., one o doors to Heritag be manually late	corridor openings in other closures of vertical or hazardous areas are as such as those constructed conded core wood, or any fire for at least 20 in sprinklered buildings are resist the passage of no impediment to the cors. Doors are provided table for keeping the door cors meeting 19.3.6.3.6 are 3.6.3 The prohibited by CMS health care facilities. For a conference rooms and 1 areak rooms would close the door frame. This is a could affect any the ensure the corridor doors are conference room and the could affect any the could affect any the ensure the corridor doors are could affect any the could affect any the could affect any the ensure the corridor core conference room could ched into the door frame, the double corridor the conference room could ched into the door frame, the conference room could ched into the door frame,	K01		for the employee break room door was immediately repaired. We have hired Moss Engineer to assist us with adding positiv latching hardware to the Herita Room door. 2. No residents waffected by this alleged deficie practice 3. Reviewed all doors the facility to assure proper closures are in place, none for 4. Maintenance Director will approve and supervise all new doors placed in the facility to	d. ring re age rere ent s in und.	03/26/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 3 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 01	(X3) DATE S COMPL	
ANDILAN	or conduction	155095		LDING		03/13/	
		100000	B. WIN			00/10/	2010
NAME OF F	PROVIDER OR SUPPLIER				DBSON RD		
HERITAG	GE PARK				VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	automatically wh						
	_	would latch into the once it was fastened					
	1	e door frame. The first					
	<u>-</u>	tive latching hardware.					
	This was acknow	· ·					
		pervisor at the time of					
	observation.	yor visor at the time UI					
	b. Based on obse	ervation with the					
		pervisor on 03/13/13 at					
	2:20 p.m., the	941 1302 011 02/12/12 40					
	-	the employee break room					
		with a magnet that would					
		vation of the fire alarm.					
	_	hing hardware did not					
	_	Once the magnetic					
		loor could be pushed					
	open. This was	_					
	l -	pervisor during the test of					
	the fire alarm sys	stem at 3:45 p.m. on					
	03/13/13.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 4 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	A. BUI	LDING	onstruction 01	(X3) DATE (COMPL 03/13/	ETED
NAME OF P	ROVIDER OR SUPPLIER		B. WIN	2001 H	ADDRESS, CITY, STATE, ZIP CODE OBSON RD VAYNE, IN 46805		
(X4) ID PREFIX TAG K010027	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=E	LIFE SAFETY CO Door openings in least a 20-minute at least 1¾-inch t core. Non-rated p exceed 48 inches door are permitte comply with 7.2.1 or automatic closi 19.2.2.2.6. Swing to swing with egre not required. 19 Based on observ facility failed to smoke barrier do movement of sm minutes. LSC 19 smoke barriers si Section 8.3.4. L in a smoke barrie leaving only the necessary for pro defined as 1/8 in practice could af compartments. Finding include: Based on observ Maintenance Sup 2:30 p.m., the co smoke barrier do at the library fail leaving a four in-	smoke barriers have at fire protection rating or are hick solid bonded wood protective plates that do not from the bottom of the d. Horizontal sliding doors .14. Doors are self-closing ng in accordance with ging doors are not required less and positive latching is 9.3.7.5, 19.3.7.6, 19.3.7.7 action and interview, the ensure 1 of 11 sets of fors would restrict the loke for at least 20 9.3.7.6 requires doors in hall comply with LSC SC 8.3.4.1 requires doors er shall close the opening minimum clearance oper operation which is ch. The deficient fect 2 of 12 smoke	KO	10027	1. The door in question was immediately readjusted.2. No residents were found to have been affected by the alleged deficient practice.3. Weekly to fall fire doors will be complet for 4 weeks to assure proper closure, then monthly thereafted Results will be reported to the Executive Director and govern CQI committee.4. The Maintenance Supervisor is responsible for rounds, reportit to ED and CQI Committee. Maintenance Supervisor is als responsible to assure any note issues are immediately correct.	ests eed er. ing ng o,	03/22/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 5 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CC A. BUILDING B. WING	01	03/13	LETED 3/2013			
HERITAC	ROVIDER OR SUPPLIER SE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) pervisor at the time of	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	observation. 3.1-19(b)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 6 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01		
		155095	B. WIN	G		03/13/	2013
NAME OF P	PROVIDER OR SUPPLIER			2001 F	ADDRESS, CITY, STATE, ZIP CODE HOBSON RD WAYNE, IN 46805		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010044 SS=E	NFPA 101 LIFE SAFETY CO Horizontal exits, it with 7.2.4. 19.2 Based on observa facility failed to a sets was arranged and latch. LSC I horizontal exits t 7.2.4 and 7.2.4.3 be self closing or accordance with NFPA 80, Standa Windows at 2-1.4 mechanisms shall overcome fire res mechanism so por achieved on each deficient practice 48 residents on the Findings include Based on observa Maintenance Sup 1:45 p.m., the we door set entering latch into the fran interview with the Supervisor at the these doors were hour fire doors as	DDE STANDARD f used, are in accordance 2.2.5 ation and interview, the ensure 1 of 2 fire door d to automatically close 19.2.2.5 requires to be in accordance with .8 requires fire doors to r automatic closing in 7.2.1.8. In addition and for Fire Doors and 4.1 requires all closing Il be adjusted to sistance of the latch to sitive latching is a door operation. This the could affect any of the the 100 and 200 halls. : ation with the the pervisor on 03/13/13 at the est fire door on the fire the 200 hall failed to the me. Based on an	K01	10044	1. The west fire door on the fi door set entering 200 hall was immediately adjusted by Maintenance staff. In addit we have hired an outside contractor to assess the warping, and correct or replace door, if needed.2. No resident was found to have be harmed by the alleged deficiely practice.3. Maintenance Supervisor is responsible for assuring the proper functionin fire doors. Fire doors will be checked weekly for 4 weeks at then monthly. Maitenance Supervisor will immediately address/correct any issues.4. Maintenance Supervisor will report all findings to the Execu Director and the governing Cocommitte monthly.	tion, een nt g of nd	03/29/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 7 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI 03/13	LETED			
	PROVIDER OR SUPPLIE GE PARK	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE			
	3.1-19(b)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

ŀ

Facility ID: 000038

If continuation sheet

Page 8 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/13/2013	
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	2001 H	ADDRESS, CITY, STATE, ZIP CODE OBSON RD VAYNE, IN 46805	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
K010064 SS=D	health care occup 9.7.4.1. 19.3.5. Based on observe facility failed to electrical room for provided mainter the fire extinguis recharging. NFF Portable Fire Ext 4-4.1 requires fir subjected to main one year apart or indicated by insp practice was not could affect kitch an emergency. Findings include Based on an obse Maintenance Sup 3:20 p.m., the gar extinguisher local electrical room in needed to be recharch.	guishers are provided in all pancies in accordance with 6, NFPA 10 ation and interview, the ensure 1 of 1 kitchen ire extinguishers was nance when the gauge on the indicated it needed PA 10, Standard for singuishers, in Section e extinguishers to be nance no more than when specifically section. This deficient in a resident care area but nen staff in the event of	K0	10064	1. The fire extinguisher was immediately replaced.2. No residents were found to be affected by the alleged deficie practice.3. A detailed diagran all fire extinguishers in the building has been created, this tool will be used to assure that every extinguisher is checked during monthly rounds.4. The Maintenance Supervisor is responsible for rounding and for reporting findings to the Exect Director and governing CQI committee. He is also responsible for assuring any issues found are corrected.	n of s t	03/29/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 9 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM 03/1	ie survey ipleted 13/2013			
NAME OF PI	ROVIDER OR SUPPLIE	TR	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805						
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 10 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155095	A. BUI	LDING	01	03/13/	
		155095	B. WIN			03/13/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE PARK				OBSON RD WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
K010144	NFPA 101					•	
SS=F	LIFE SAFETY CO						
		spected weekly and oad for 30 minutes per					
		nce with NFPA 99.					
	3.4.4.1.						
	Based on record	review and interview, the	K0	10144	1. We have hired WW William	ıs	03/29/2013
	facility failed to	ensure 1 of 1 emergency			to provide a Load Bank, cablin	ıg,	
	generators could	provide electrical power			hook up and disconnection of Load Bank, testing will be for 2)	
	to the facility wit	thin 10 seconds of the			hours and will be performed in		
	loss of normal el	ectrical power. LSC			accordance with the 2010 NFF		
	7.9.2.3 and NFP.	A 99, Health Care			110 Regulation 8.4.9.2. No		
	Facilities, 3-4.1.1	1.8 requires the generator			residents were found to have		
	set shall have sut	fficient capacity to pick			been affected by the alleged deficient practice.3. Maintena	nce	
	up the load and r	neet the minimum			Supervisor will assure testing		
	frequency and vo	oltage stability			changes are completed by WV		
		the emergency system			Williams.4. Maintenance		
	•	ls after loss of normal			Supervisor will notify the Executive Director and govern	ina	
	power. This defi	icient practice affects all			CQI committee monthly of reu		
	occupants.	•			of emergency generator testing		
					He will be responsible for assuring the transfer of power	in	
	Findings include	:			10 seconds or less and taking		
					corrective action, if needed.		
	Based on review	of the "Emergency					
	Generator - Wee	kly Exercise/Monthly					
	Load Test Log"	with the Maintenance					
	Supervisor on 03	3/13/13 at 12:48 p.m., the					
	monthly load tes	t record indicated the					
	_	r from the main source to					
	the emergency g	enerator took fifteen					
	seconds in Octob	per and December of					
	2012 and Februa	ry of 2013. This was					
	confirmed by the	Maintenance Supervisor					
	at the time of rec	cord review.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet

Page 11 of 12

PRINTED: 03/27/2013 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMI 03/1	PLETED 3/2013			
PROVIDER OR SUPPLIER GE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805						
GE PARK SUMMARY S (EACH DEFICIEN		STREET A 2001 H	OBSON RD	CODE ORRECTION SHOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8LY21

Facility ID: 000038

If continuation sheet Page 12 of 12